OFFICE OF THE DEPUTY MAYOR FOR HEALTH AND HUMAN SERVICES

AVAILABILITY OF OLMSTEAD PLAN FOR PUBLIC REVIEW AND COMMENT

The Deputy Mayor for Health and Human Services announces availability of the Olmstead Plan for public review and comment.

In August 2015, Mayor Muriel Bowser created an Olmstead Working Group to bring advocates, stakeholders, and government together to assess the District of Columbia's programs for enabling *Everyone* in the District of Columbia to be on a solid pathway to the middle class.

The 2016 Olmstead Plan presents the District's roadmap to becoming a city that supports all of its residents to be on a solid pathway to the middle class.

The Olmstead Plan is are available for review in the November 27, 2015 issue of the DC Register and on the Web page for the Office of the Deputy Mayor for Health and Human Services at http://dmhhs.dc.gov/.

Comments should be sent via email to olmstead@dc.gov beginning on Friday, November 27, 2015 through NOON on Monday, December 28, 2015.

If you have questions or require additional information, please contact:

Tanya Reid
500 K Street, NE,
Washington, DC 20002
olmstead@dc.gov

Dear Fellow Washingtonians:

A fundamental measure of any great city is how well it supports all residents to live successfully in thriving communities. *Everyone* in the District of Columbia should be on a solid pathway to the middle class, with real education, employment, and housing opportunities paving the way.

For people with disabilities, making good on this promise means ensuring access to a full slate of supportive resources; responding to crises and needs with robust assistance; and strengthening families, community organizations and technology, among other supports.

Our city has made significant progress towards these goals. We have reduced to a bare minimum the number of "institutional beds" we rely on, focusing instead on supporting people to live fully integrated lives at home or in the community. This year, United Cerebral Palsy ranked us eighth in the nation (and the most improved state) for how well we serve individuals with intellectual and developmental disabilities. In 2014, AARP ranked the District 11th on its scorecard of states' efforts to provide long-term services and supports for older adults, people with physical disabilities, and family caregivers.

But despite our successes, we still have some work to do. In many areas, our performance is not where we want it to be, and a history of limited data collection makes it hard to know with precision how we are doing. The District's "2015 Olmstead Plan" illustrates our legal compliance with the vision and directives of the Americans with Disabilities Act and other court orders. I want us to do even more.

To reach our goals we will rely on people to leverage the support of family and friends. We will also need strong working partnerships between government and the community – an inclusive effort in which people with disabilities drive how the city does its work while also holding us accountable for the results we all want. Our ethos must be to do "with" and not "for."

To that end, in August 2015 I created an Olmstead Working Group to bring advocates, stakeholders and government together to assess in detail where we are and where we need to go. I am proud to present here the initial results of that work. This 2016 Olmstead Plan is our roadmap to becoming a city that supports all of its residents living the robust and independent lives they want and deserve.

Sincerely,

Muriel Bowser, Mayor

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SECTION 1:
Overview

I. What is an Olmstead Plan?

In 1990, the Americans with Disabilities Act (ADA) was signed into law, prohibiting state and local governments from discriminating against people with disabilities and/or excluding them from participating in, or receiving benefits from, government services, programs, or activities. One part of the federal regulations implementing the ADA requires state and local governments to "administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities."[i] This is often called the ADA's "integration mandate."

Nearly 10 years later, disagreement over what the integration mandate required made its way to the U.S. Supreme Court. In *Olmstead v. L.C.,*[ii] the Supreme Court ruled that people with disabilities have the right, under certain circumstances, to live and receive care in the community rather than in an institutional setting. In this 1999 decision, the Supreme Court also indicated that states could have a "comprehensive, effectively working plan" to demonstrate compliance with the ADA's integration mandate. These plans are often referred to as "Olmstead plans."

Under Olmstead, states must provide services to people with disabilities in integrated setting, within certain limits:

- First, the person must want community-based services.
- Second, a person's treatment team must consider community-based services appropriate.
- Third, it must be reasonable to accommodate the community-based services, taking into account state resources and the needs of others with disabilities.

More than half of the states have an Olmstead plan to ensure that services, programs, and structures comply with the vision and directives of the integration mandate.

Olmstead Planning in the District of Columbia

In 2006, the District of Columbia government passed the Disability Rights Protection Act, which created the Office of Disability Rights (ODR). Among other things, ODR was given responsibility for developing and submitting an Olmstead Compliance Plan. ODR published the District's first Olmstead Plan in 2011, and the city has since made numerous revisions based on stakeholder feedback.

On January 2, 2015, Muriel Bowser was inaugurated as the eighth Mayor of the District of Columbia. Under her leadership, the District created an Olmstead Working Group to make recommendations for revisions to the Olmstead Plan for 2016, and into the future. The Olmstead Working Group was developed with the advice and recommendations of ODR and other agencies serving people with disabilities. The group is comprised of representatives from District agencies as well as community stakeholders, including people with disabilities and advocates for people with disabilities.[iii]

ODR is the agency in charge of developing the Olmstead Plan, and the Deputy Mayor for Health and Human Services has provided substantial support and oversight in development of this 2016 iteration. ODR will continue to coordinate the reporting required under the Olmstead Plan and submit recommendations to the Mayor as appropriate.

Which People are the Focus of DC's Olmstead Plan?

There is currently no single source of data on the number of people in the District of Columbia who have a disability. Estimates vary based on the definition of disability that is used, whether people self-identify as having a disability, and other factors. The ADA uses an expansive definition of disability because it is a comprehensive civil rights law.

While all District residents are supported by a city that is fully accessible, in FY 2015, 21,496 people were directly served in some way by the District government with Medicaid-funded services commonly considered to be supportive of people with disabilities.[iv] Among these individuals:

1. About 1 in 5 (approximately 4,000 people, or 18% of the estimated total) were receiving support in an institutional setting, such as a nursing home, psychiatric residential treatment facility or intermediate care facility.
2. The remaining 82% (approximately 17,000 people) were living in a community-based setting.
3. In FY 2015, 1,016 people entered institutional care and 357 transitioned from such care to life in the community.

The Olmstead Plan is intended to focus, in particular, on people with disabilities who are at risk of institutionalization. There are currently 3,650 people with disabilities (or 21% of those currently living in the community) whose level of need qualifies them for institutional care, but who are receiving services designed to enable them to remain in the community instead. For purposes of this 2016 plan, these people represent the group considered most "at risk" for institutionalization.

II. Understanding DC's Service Structure for People with Disabilities

People with disabilities can have a broad range of medical and personal care assistance needs, from support for daily living activities – like preparing meals, managing medication and housekeeping – to help accomplishing basic activities like eating, bathing, and dressing. They may require help training for and securing a job, or special accommodations to do the job as required. These various forms of assistance (known as "Long Term Services and Supports," or LTSS) are most often provided informally through unpaid caregivers like family and friends. But they can also be provided by professionals who serve people in institutions, in a person's home, or in a community-based setting.

Who Provides These Services?

The District's service system for people with disabilities is comprised of multiple government agencies, public and private institutions that provide residential care, as well as local organizations that receive District and federal funds to provide home- and community-based services. All of these components of the service system are described below.

Government Agencies

- **Department of Behavioral Health (DBH)**

  DBH provides prevention, screening and assessment, intervention, and treatment and recovery services and supports for children, youth, and adults with mental health and/or substance use problems. Services include emergency psychiatric care, residential services and community-based outpatient care. DBH also operates Saint Elizabeths Hospital, which is the District's inpatient psychiatric facility.

- **Department of Health (DOH)**

  The DOH Health and Intermediate Care Facility Divisions administer all District and federal laws and regulations governing the licensure, certification and regulation of all health care facilities in the District of Columbia[v]. In this role, Health Regulation and Licensing Administration (HRLA) staff inspect health care facilities and providers who participate in the Medicare and Medicaid programs, certified per District and federal laws, respond to consumer and self-reported facility incidents and/or complaints, and conduct investigations, if indicated. When necessary, HRLA takes enforcement actions to compel facilities, providers and suppliers to come into compliance with District and Federal law.

- **Department of Health Care Finance (DHCF)**

  DHCF is the District's Medicaid agency and the primary payer for all long term services and supports the city provides. In fiscal year 2014,[vi] the District spent a total of $781 million in Medicaid funds on these services; $245 million (or 30%) were local dollars. These funds pay for care in institutional settings including nursing facilities and Intermediate Care Facilities for Individuals with Intellectual and Developmental Disabilities (ICF/IDDs), as well as a variety of home and community-based services (HCBS), described below. Approximately 45% of total Medicaid funds spent on LTSS are spent on institutional care while 55% are spent on home and community-based services.

- **Department of Human Services (DHS)**

  Across its extensive range of programming, DHS routinely serves people with disabilities. For example, in income-based programs such as TANF, SNAP, and Medicaid, approximately 17% of applicants were assessed as likely to have a mental disorder of some magnitude, and 4% to have a learning disability. In the homeless services program, 40% of singles and 16% of adult head of families entering shelters were assessed by DHS to have a disability in at least one of eight categories.[vii] In the Adult Protective Services program -- which investigates reports of abuse, neglect, exploitation and self-neglect, and provides temporary services and supports in some founded cases -- an estimated 45% of those served area assessed to have a disability.

- **D.C. Office on Aging (DCOA)**

  DCOA manages the Aging and Disability Resource Center (ADRC) and funds the Senior Service Network, which together consist of more than 20 community-based nonprofit organizations, operating more than 40 programs for District residents age 60 and older, people living with disabilities (age 18-59), and their caregivers. In addition, the ADRC

provides information, coordinates service access, and provides direct social work services to help people stay in the community for as long as possible. In FY 2015, the ADRC served 5,860 people, 23% of whom were 18 to 59 years old, living with a disability. The remaining individuals served by ADRC are people age 60 and older who may also have a disability.

- **Department on Disability Services (DDS)**

  DDS oversees and coordinates services for District residents with disabilities through a network of community-based, service providers. Within DDS, the Developmental Disabilities Administration (DDA) coordinates person-centered home and community services for over 2,250 adults with intellectual disabilities so each person can live and work in the neighborhood of his or her choosing. DDA promotes health, wellness and a high quality of life through service coordination and monitoring, clinical supports, and a robust quality management program.

  DDS's Rehabilitation Services Administration (RSA) provides comprehensive, person-centered employment services and supports for people with disabilities, pre-employment and transition services for youth with disabilities, independent living services and services for people with visual impairments. In FY 2015 RSA served 9,075 people.

- **Office of Disability Rights (ODR)**

  ODR assesses and evaluates all District agencies' compliance with the ADA and other disability rights laws, providing informal pre-complaint investigation and dispute resolution. ODR also provides expertise, training and technical assistance regarding ADA compliance and disability sensitivity and rights training to all DC agencies. ODR's current initiatives include efforts to increase access to District-owned and leased facilities, worksites and community spaces; leading monthly disability-wellness seminars and managing the District's Mentoring Program for students with disabilities.

- **Office of the State Superintendent for Education (OSSE).**

  The office of the State Superintendent of Education (OSSE) is the District's state education agency. OSSE is responsible for ensuring that all education-related public agencies identify and evaluate children who may have a disability and provide an education that meets the children's individualized needs alongside peers without disabilities to the maximum extent appropriate. OSSE also has oversight of nonpublic special education schools -- the most restrictive educational placements for children with disabilities. DC currently serves 12,173 children with qualifying disabilities ages 3-

21. In addition, OSSE oversees early intervention services for approximately 700 infants and toddlers with qualifying disabilities (age 3 and under). Finally, OSSE provides daily transportation to school for eligible children with approximately 650 buses running over 500 routes each weekday.

- **Other Government Agencies**

  Many other agencies in the District of Columbia serve and support people with disabilities. In doing so, they interface on a regular basis with the agencies listed above. These other government agencies include:

  - The DC Housing Authority (DCHA)
  - The DC Public Libraries (DCPL)
  - The DC Public Schools (DCPS)
  - The Department of Child and Family Services (CFSA)
  - The Department of Corrections (DOC)
  - The Department of Housing and Community Development (DHCD)
  - The Department of Employment Services (DOES)
  - The Department of Parks and Recreation (DPR)
  - The Department of Youth Rehabilitation Services (DYRS)

Institutional Care Providers

Over the last several decades, the District of Columbia has worked to reduce the number of institutional care settings for people with disabilities in favor of home and community based alternatives. In 1991, the city closed the Forest Haven facility for children and adults with intellectual and developmental disabilities and, over the course of the past 25 years, the population of St. Elizabeths Hospital has been reduced from several thousand to less than 300. Today, the District operates or pays for services in only three types of institutional care settings: inpatient facilities, intermediate care facilities, and nursing facilities.

- **Inpatient Facilities**

  Saint Elizabeths Hospital is the only inpatient psychiatric facility operated by the District of Columbia. This 292-bed tertiary care facility provides in-patient psychiatric treatment to individuals with serious mental illnesses.

  - Total bed capacity: 292
  - Average daily census during FY15: 275[viii]
  - Total new admissions monthly: 458 admissions in total (38 per month)[ix]
  - Total discharges to the community: 464 discharges in total (39 per month):

        - 1-20 days: 48 (10%)
        - 21-90 days: 253 (55%)
        - 90+ days: 163 (35%)[x]
    - Median length of stay (LOS): for 'discharge cohort' (measured at discharge) was 58 days and average LOS was 483 days. Median LOS for individuals remaining in care at end of FY15 (9/30/15) was 466 days and their average LOS was 2400 days.
    - Average cost per person/funding source: The per diem rate for all individuals in care (both forensic and civil) was $901.

Through Medicaid, the District also pays for inpatient psychiatric care for youth in 50 facilities (known as psychiatric residential treatment facilities, or PRTFs), all of which are located outside of the District.

- Total Census:[xi]128 District youth were in PRTF placements during FY14
- Total new admissions monthly: 6.3 admissions per month
- Total discharges to the community:
    - 1-20 days – one youth
    - 21-90 days-14 youth
    - 90+ days- 113 youth
- Average length of stay: 8 months

Finally, the District's Hospital for Sick Children, provides long-term chronic, acute or rehabilitative services for children.

- Total bed capacity: 130 licensed beds/118 operating beds
- Total census: 39
- Total new admissions: 173
- Total transitions to the community: 199
- Average cost per patient per day: $2,485 (85% Medicaid)
- Average length of stay: 69 days

- **Intermediate Care Facilities (ICFs)**

ICFs for people with intellectual and developmental disabilities (ICF/IDD) provide comprehensive residential, day, clinical and medical services by a certified provider. The District does not operate any ICF/IDDs, but pays for intermediate care in 68 private facilities.

Between FY 2007 and FY 2015, the District intentionally reduced the total ICF/IDD capacity by 233 beds, and residents by 213 people -- a 40% reduction in the use of these institutional services. As of the close of FY 2014:

- Total bed capacity: 400
- Total census: 354
- Total new admissions: 4
- Total transitions to the community: 3
- Average length of stay: People typically live in an ICF/IDD home for a number of years (as many as 20 for example).
- Average annual cost per person: $177,886

- **Nursing Facilities**

Nursing facilities, regulated by the Department of Health, provide both short- and long-term care for individuals who require skilled nursing, supervision and assistance with activities of daily living. The District does not directly operate any nursing facilities. Medicaid is the single largest payer for nursing facility services, along with Medicare and private pay.

- Total number of DC-based facilities: 21[xii]
- Total bed capacity: 2,770
- Total current census: 2,717 total users in Q4
- Total new admissions: 975
- Total transitions to the community[xiii]:
  - 1-20 days: 9 individuals
  - 21-90 days: 37 individuals
  - More than 90 days: 37 individuals[xiv]
- Average length of stay: 537 days
- Average cost per person per day: Medicaid paid $193.50/person per day for nursing facility services in FY14.

Home and Community-Based Services

The District of Columbia offers a wide variety of home and community-based supports and services (HCBS) for people with disabilities. These range from comprehensive adult day health programs to vocational rehabilitation to wellness classes. Depending on the program or service, eligibility is based on a person's age, income and/or the level of care they need.

- **Medicaid Waivers & Demonstration Projects**

  The District operates three Medicaid programs that enable community living for people who would otherwise be eligible for institutional care based on their level of care need (in an ICF or nursing home). The long-term services and supports provided under these programs are funded with a combination of federal and local Medicaid dollars.

  - *The ID/DD Waiver* offers 24 different services for individuals with developmental and intellectual disabilities offered by community providers certified by DDS. These include: day services such as supported employment and individualized day supports; residential services such as supported living and in home supports; clinical supports such as creative art therapies, wellness, and physical and occupational therapy; and assistive supports such as environmental accessibility adaptations, personal and emergency response services and vehicle modification.[xv]
    - Enrollees: 1,644[xvi]
    - Cap: 1,692
    - FY 2015 total budgeted: $192,837,582
    - FY 2015 total spent: $191,940,457

  - *The Elderly and Persons with Disabilities (EPD) Waiver* supports individuals who are age 65 and older, or between 18 and 64 and have a physical disability. As of January 1, 2016, there are 13 services offered in the EPD waiver including: case management, personal care assistance, respite, environmental accessibility, occupational and physical therapy, assisted Living, and others.[xvii][xviii]
    - Enrollees: 2,006[xix]
    - Cap: 4,960
    - Total budgeted: $26,488,352
    - Total spent: $26,703,283

  - *The Money Follows the Person Program* (MFP) supports individuals who are making the transition from institutional care to an HCBS setting. The intensive wrap-around services also include funds to cover "set-up" costs incurred as part of the transition. Since 2008, the Demonstration has provided transition coordination services for over 200 Medicaid beneficiaries to return to the community.

- **"State Plan" Support**

  People with disabilities may also access community based services and supports through the District's Community Medicaid program (called the "State Plan"). Covered services include personal care assistance, hospice, adult day health, home health, occupational therapy, physical therapy, and skilled nursing services. The Developmental Disabilities Administration also provides service coordination for people receiving state plan services or local funding. State Plan services for mental health, substance use disorder, and Health Homes for people with mental illness are described separately below.

    - Number of state plan enrollees receiving Long Term Services and Supports: 15,315

- **Assisted Living**[xx]

  Assisted living facilities (ALFs) provide housing, health and personalized assistance according to individually developed service plans. These facilities vary greatly in the room configurations and amenities they offer. The District licenses 13 ALFs, three of which are used by Medicaid recipients via the EPD waiver. One of these, The Marigold, is a public housing assisted living facility operated by the city's Housing Authority (DCHA) in partnership with a private contractor. In the three facilities:

  - Total bed capacity: 61
  - Total current census: 34
  - Total new admissions: 16

  The Department of Behavioral Health operates two types of assisted living facilities, called Mental Health Community Residence Facilities (MHCRFs):

  - S upported Residences (SR) for individuals who need less intense support to live in the community.
    - Total bed capacity: 432
    - Total current census: 385
  - S upported Rehabilitative Residences (SRR) which provide twenty-four hour supervision for individuals with severe and persistent mental illness who need an intense level of support to live within the community.

- Total bed capacity: 205
- Total current census: 198

To support assisted living, the District also participates in the *Optional State Supplemental Payment Program* which supplements the income of low-income older adults and individuals with disabilities to help them pay for housing in licensed Adult Foster Care Home (AFCHs). AFCHs include licensed Community Residential Facilities (CRFs), Assisted Living Facilities (ALFs) and Mental Health Community Residential Facilities (MHCRFs). For 2016, the OSSP payment (issued directly to the participant) ranges from $620 to $730 for an individual and from $1,606 to $1,825 for a couple. In FY 2014, 7,807 people received OSSP support.

- **Employment and Wrap Around Services for People with Disabilities**

The Department on Disability Services uses a person-centered approach to provide extensive wrap around services to support eligible people with disabilities to live as independently as possible in the community. Services include:

- Counseling and guidance
- Payment for vocational and other training services, or college
- Assistive technology (e.g., I-pad touch, Zoom Text; Dragon Speak; hearing aids, etc.)
- Visual impairment services
- Transportation necessary to participate in training
- Clothing and equipment needed for work
- Transition services for youth still in school

In addition, the Independent Living Services (ILS) program partners with the DC Center for Independent Living and other private agencies to provide four core independent living services: advocacy; independent living skills training; information and referral; and peer support. The Independent Living Older Blind Program (ILOB) provides in-home and community-based services for this specialized population.

- **Housing Support**

Securing affordable, appropriate housing is often a significant challenge for people with disabilities whose incomes may be limited and their physical needs very specific. There are some housing resources targeted for this population. For example, the Department of

Behavioral Health provides a range of housing options for individuals with mental illness including over 2,000 subsidized community-based housing units. DDA funds housing supports for approximately 960 people enrolled in the IDD waiver who require out of home residential supports. In addition, there are 65 funded housing choice vouchers for people in the MFP initiative described above.

The Department of Housing and Community Development (DHCD)'s Handicapped Accessibility Improvement Program (HAIP) supports critical home modifications and adaptations costing $10,000-$30,000. Home modifications up to $10,000 are also covered expenses in the EPD and the IDD waivers.

- **Mental health and substance abuse services**

  There are currently eleven Mental Health Rehabilitation Services: diagnostic and assessment; mediation somatic; counseling; community support; crisis/emergency; rehabilitation day services (mentioned above); intensive day treatment; community based intervention for children and youth; assertive community treatment for adults; trauma-focused cognitive behavioral therapy for youth and child-parent psychotherapy – Family Violence, also for youth. These services are offered through community providers - Core Services Agencies (CSAs) or specialty providers - who are certified by DBH. At least 60% of the services are required to be provided in the community in natural settings, rather than at the clinic.

  In addition to Medicaid–reimbursable treatment services, DBH offers numerous other supportive services for people with mental illness such as rental subsidies and Supported Employment. DBH also certifies Substance Use Disorder (SUD) treatment and recovery providers in the District who provide clinical care coordination; assessment/diagnostic and treatment planning; counseling; medication management and a variety of other services

- **Wellness, Fitness and Nutrition**

  The DC Office on Aging and Department of Parks and Recreation combine to provide a broad range of wellness and fitness programs, classes and activities that support people in maintaining healthy lives in their communities. In addition to wellness and day treatment programs, services include transportation, home delivered meals, congregate meals, and nutritional supplements.

- **Day Services**

  DDS, DCOA, DHCF, DBH and a host of community-based providers combine to offer a variety of day services for adults with intellectual disabilities, frail elderly, people with physical disabilities, and people with mental health diagnoses. These services all work to support individuals in living an integrated and independent life in the community. Program examples include:

  - *Individualized Day Supports (IDS)* to foster independence, encourage community integration, and help people build relationships. IDS include vocational exploration and can supplement employment services.

  - *Adult Day Health Services* offer non-residential medical supports and supervised therapeutic activities in an integrated community setting.

  - *Geriatric Day Care* provides supervision, socialization, rehabilitation, training, therapy and supportive services for functionally-impaired seniors to help them remain in their homes.

  - *Rehabilitation Day Services* is a structured clinical program to develop skills and foster social role integration through a range of social, psycho educational, behavioral and cognitive mental health interventions.

- **Transportation**

  The District provides Medicaid-funded emergency and non-emergency transportation support to people who are eligible, as well as non-Medicaid transportation through several providers. The primary objective is to provide low-income, functionally impaired District residents with transportation to life-sustaining medical appointments so they can maintain maximum functioning and independence in the community.

  In addition, the District Department of Transportation (DDOT) works with the Washington Metro Area Transit Authority (WMATA) and the D.C. Taxi Commission to provide broader transportation services to District residents living with a disability. “MetroAccess” is a shared-ride, door-to-door, paratransit service for people whose disability prevents them from using bus or rail. The “Transport DC” program (formerly CAPS-DC) provides alternative taxicab transportation for MetroAccess customers. The D.C. Office on Aging also funds a transportation program through Seabury Resources for the Aging, primarily for medical appointments, but also available for group social outings.

How Do People Access Long Term Services and Supports (LTSS)?

The District's goal is to make it as simple and seamless as possible for people with disabilities to access the variety of Long Term Services and Supports described above. If an individual is living at home or in the community, multiple agencies provide information and referrals to these services. For people temporarily in an institutional care setting, discharge and community transition processes can be set in motion.

Information and Referral to Services within the Community

Information about Long Term Services and Supports (what's offered, who's eligible, how to apply) is available through multiple District agencies. These agencies either support people in applying for services they offer, or provide referrals to other agencies.

District residents are also directed to the city's **Aging and Disability Resource Center (ADRC)**, which is the most comprehensive source of information for connecting residents to Long Term Services and Supports. The ADRC is operated by the DC Office on Aging and has eight satellite offices around the city, one in each Ward. The ADRC's Information and Referral/Assistance Unit uses "Person-Centered Options Counseling" and refers people to:

- Community-based, private sector resources.
- DC government health and human service programs.
- A Medicaid Enrollment Specialist who can assist with pre-enrollment for the EPD Waiver.
- Community case managers or social workers, if the resident is eligible and in need of home- and community-based services and supports right away.

The DC Office on Aging also uses Benefits Checkup through its Senior Service Network and the ADRC to help people identify which services they might be eligible for (including local and federal programs) that are close to where they live. Benefits Checkup uses a simple online questionnaire; users do not have to provide identifying information such as name or social security number. The system identifies eligibility matches for all available home and community-based services in the District.

Transitioning from an Institutional Setting

The District government has established processes by which people with disabilities are helped to transition from institutional care settings to a less restrictive environment.

- *For people with intellectual and developmental disabilities,* DDS coordinates transition planning and support. If a person had already been served by DDA, admission to a nursing home would trigger enhanced monitoring to ensure the setting remains the least restrictive to meet the person's needs. People who reside in ICF/IDD settings are offered on at least an annual basis the opportunity to receive services under the IDD HCBS waiver as an alternative to ICF services during person-centered planning meetings.
- *For people over the age of 60 or adults with physical disabilities,* transition assistance is conducted by staff in the facility in conjunction with the ADRC. The process uses a uniform preference screening tool and transition services checklists. Decisions about the appropriateness of a less restrictive setting are ultimately made by the resident and his or her legally authorized representative, social worker, medical professional, and other members of the individual's care team. Once the individual has been successfully transitioned back to the community, ongoing case management services are available through the District's EPD Waiver program, Money Follows the Person Program, or DCOA's Senior Service Network[xxi].
- *For youth with mental health issues being discharged from PRTFs,* DBH has a very vigorous process to ensure youth are successfully integrated back into the community. DBH has staff assigned to every youth in a PRTF, visiting the youth in person and participating in all treatment team meetings. Prior to discharge, a Core Service Agency (CSA) is assigned if no relationship previously existed. Working with the youth and his or her family (if any), the PRTF staff, DBH monitor, CSA and any other involved District agencies develop a discharge plan that includes not only mental health services but also housing, education and other support services as needed.
- *For people discharged from Saint Elizabeths Hospital,* transition planning starts from the day of admission. A Core Service Agency (CSA) is assigned if no relationship previously existed, and CSA staff participate in all aspects of discharge planning. Upon anticipation of discharge, but no earlier than 90 days prior, the individual can be referred to Rehabilitation Day Services, which occur in the community, to enable him or her to start the transition out of the hospital. The type of housing needed is identified, and the individual is supported to identify a residence to move to upon discharge. The discharge plan is developed with the individual so that services can begin immediately upon discharge.

III. District-Level Work to Improve Long Term Services and Supports

The District has yet to achieve its goal of fully seamless access to Long Term Services and Supports. Many individuals and families seeking this help encounter a fragmented, inconsistent and siloed system that requires multiple assessments and applications as well as lengthy delays in approval. Once enrolled, the quality of services can be inconsistent. Residents who have limited English proficiency may face additional barriers in accessing linguistically appropriate services.

Section 2 of this Plan details these challenges and lays-out specific action steps in nine strategic areas. That work will take place within the context of a number of District-level initiatives aimed at systems improvement. A strong advocacy community lends its support and oversight.

On-Going District-Level Initiatives

There are a number of initiatives currently underway in the District working to assess, and make concrete improvements to, various aspects of the Long Term Services and Supports system. These initiatives include:

- **Age-Friendly DC**

  In 2012, DC adopted World Health Organization (WHO) guidance to prepare for the growing number of residents aged 50 and older, by transforming built, natural, and social environments into great places to grow up and grow older. The WHO outlined a framework for creating age-friendly cities and communities through four phases: 1) assessment; 2) planning; 3) implementation; and 4) evaluation. The District is implementing 75 strategies led by 38 DC agencies to transform the city by 2017 into an easier city to live and visit. The Age-Friendly DC strategies are closely aligned with this Olmstead Plan and will help it move forward. Data in the 2017 Olmstead Plan will also help measure progress in transforming DC into an age-friendlier community. More information at: www.agefriendly.dc.gov.

- **DHCF System Reform Efforts**

  DHCF is undertaking major system reforms to improve the quality and delivery of Medicaid–funded Long Term Services and Supports. The work is focused in three areas: organizational change; program evolution and growth; and quality improvement. The

numerous specific activities in this effort can be found in the nine priority areas detailed in Section 2 of this plan.

- **Employment First State Leadership Mentoring**

  People with disabilities in the District experience disproportionate unemployment. In 2012, a Mayoral Proclamation made the District of Columbia the 20th "Employment First State," a commitment to supporting people with disabilities in pursuing competitive employment in integrated settings and *as the first option explored in publicly-funded services*. To realize this vision, a cross-agency Employment First State Leadership Mentoring Program is helping develop initiatives to increase the capacity of provider and District staff in key agencies to more effectively advance Employment First strategies with a focus on transition age youth and customized employment. More information at: http://dds.dc.gov/page/employment-first

- **The National Core Indicators (NCI)**

  The National Core Indicators (NCI) initiative helps state agencies gather a standard set of performance and outcome measures that can be used to track their own progress over time and compare results across the country. Until recently, NCI has focused on efforts by public developmental disabilities agencies on employment, rights, service planning, community inclusion, and other areas. NCI recently expanded its scope to support states in assessing their performance for older adults, individuals with physical disabilities, and caregivers. For the last two years, the District has participated in NCI and will begin to use the expanded scope in 2017 and 2018. DDA's current NCI reports can be reviewed on-line at: http://www.nationalcoreindicators.org/states/DC/.

- **No Wrong Door (NWD)**

  In 2014, DC was one of 25 states to receive a year-long federal planning grant through the U.S. Administration for Community Living to develop a comprehensive, "No Wrong Door" (NWD) approach to the delivery of Long Term Services and Supports. In FY 2015, DC was one of five states to receive a three year NWD implementation grant. DC's goal is a visible, trustworthy, easy-to-access system in which people encounter person- and family-centered systems and staff with core competencies that facilitate their connection to formal and informal LTSS, regardless of where they enter the system.[xxii] The NWD Work Plan is referenced frequently in Section 2 of this report as it targets many of the same goals, outcomes, challenges, and strategies as the Olmstead plan.

- **State Innovation Model (SIM)**

  In a year-long, federally funded planning process, multiple agencies and stakeholders[xxiii] are coming together to develop DC's strategy for health system transformation. The work is focusing on care delivery; payment models; community linkages; Health Information Exchange; and quality measurement as well as design of the District's second Medicaid Health Home State Plan benefit. This benefit will achieve whole-person, person-centered integrated care services coordination for people with two or more physical chronic health conditions. Many people with disabilities, due to co-morbid physical chronic conditions, will be eligible for this Health Home benefit.

The Advocacy Community

The District of Columbia has a robust community of advocates and stakeholder organizations actively involved in working to improve services and supports for people with disabilities. Examples include:

- **The DC Developmental Disabilities Council (DDC)**

  The DDC is an independent, federally-funded, Mayorally-appointed body. The DDC works to strengthen the voice of people with developmental disabilities and their families in DC in support of greater independence, inclusion, empowerment and the pursuit of life as they choose. The DDC strives through its advocacy to create change that eliminates discrimination and removes barriers to full inclusion.

- **Project ACTION!**

  Project ACTION! is a coalition of self-advocates and self-advocacy groups that shares personal experiences of living with developmental disabilities and trains and encourages peers to speak out on issues important to them. The group's motto, is "Nothing About Us without Us." Many members have joined boards, committees, work groups, and commissions that make decisions that affect their lives.

- **Supporting Families Community of Practice**

  For the past three years, the District has been working to create an active, broad-based "Supporting Families of People with Intellectual and Developmental Disabilities Across the Lifespan Community of Practice (the DC SFCoP). The group's State Team meetings often engage 50 or more people, most of whom are people with disabilities and their families. The DC SFCoP has developed processes for strengthening the voices of families and self-

advocates, trained trainers, and helped pass legislation to create a Family Support Council and to provide stipends for family and self-advocates for expenses related to participating in stakeholder engagement activities.

- **The DC State Rehabilitation Council (DC SRC)**.

  The DC SRC advises on the needs of District residents with disabilities who receive, or are seeking, vocational services from DDS's Rehabilitation Services Administration. DC SRC partners with RSA on increasing meaningful employment outcomes, developing the agency's annual goals and priorities, crafting agency policies, and tracking performance. Members of the DC SRC are appointed by the Mayor, and include consumers of RSA services, advocates, and other stakeholders.

- **The DC Statewide Independent Living Council (SILC)**

  The DC SILC promotes independent living services for DC residents with disabilities. Members are appointed by the Mayor and include advocates, individuals with disabilities, and other stakeholders in IL services. The goals for the DC SILC this year are to expand IL services District-wide; ensure that residents with disabilities are aware of IL services; increase advocacy; and support an effective and efficient IL service delivery system.

The 2016 and 2017 Olmstead Plans

While Long Term Services and Supports in the District have seen improvements since the first Olmstead Plan was developed in 2011, much work remains to be done.

The Vision

By the end of 2017, the work under the Olmstead Plans results in a person-centered, user friendly LTSS system that supports all people with disabilities to maintain their independence as long as possible in their homes; and remain fully included members of their communities.

But the Olmstead promise of community integration is more than just moving people out of institutions and into group homes in the community. The spirit of Olmstead means recognizing that all people with disabilities can and should be a part of the community and have lives that are full of opportunities:

- To work real, competitive jobs, in the community, and be paid full wages for their efforts.
- To volunteer and contribute.

- To make and be friends.
- To make decisions about their lives.
- To have a full life in a place where people with disabilities are encouraged to have hopes and dreams and are supported to reach their goals.

In collaboration with the agencies, partners and initiatives described above, the Olmstead Working Group envisions a two-stage process for building a Plan that it is a vehicle for achieving this vision.

Phase I: Establishing the Needed Knowledge Base

Recognizing significant gaps in core data about both the population and the current service system, the Working Group sees 2016 as the period during which the Olmstead Plan – with greater input and participation from a broad array of stakeholders – drives the city towards the knowledge base that will be required to make needed policy and systems decisions and then move them forward. Where there is already sufficient data to inform clear objectives, the 2016 Plan includes this information. Where data are not available, this plan establishes a marker so that the gap can be addressed in the near future.

Phase II: Development of the 2017 Olmstead Plan

With improved data – or a plan to secure this information where it does not yet exist – the District will be positioned to articulate and move forward a comprehensive set of improvements to the city's system of Long Term Services and Supports for people with disabilities.

The District will continue reporting its progress on the goals identified in the 2016 Olmstead Plan on a quarterly basis. In 2016, the quarters end on March 31, June 30, September 30, and December 31. The Office of Disability Rights will post quarterly reports within 45 days of these dates. In addition, ODR will post a year-end report within 45 days of the end of the calendar year, summarizing the District's progress for the year.

The Olmstead Working Group will continue to meet on at least a quarterly basis (after the quarterly reports are posted) to review and discuss the District's progress. By September 30, 2016, the Olmstead Working Group will present any recommendations for the 2017 Olmstead Plan to the Mayor (through the Deputy Mayor for Health and Human Services) for consideration.

SECTION 2:
The 2016 Olmstead Plan

The Olmstead Working Group has identified nine strategic areas in which the District must improve data collection and the provision of services and supports. While there is certainly overlap among these, for organizational purposes each is presented separately here. The nine areas (presented alphabetically) are:

- A Person-Centered Culture
- Community Engagement, Outreach and Training
- Employment
- Housing
- Intake, Enrollment and Discharge Processes
- Quality of Institutional and Community-Based Services, Providers and Workforce
- Supporting Children and Youth
- Waiver Management and Systems issues
- Wellness and Quality of Life

In each strategic area, this plan lays out:

The Backdrop. The importance of the issue and some of the specific challenges in DC's current operations, both for institutions and for providers of home and community-based services.

The Vision. Where work in this area is headed and aspirations for the end result.

The Data. What is currently known and what is missing.

Key Problems. The barriers and challenges that make it difficult to achieve goals in this area.

Action Steps and Lead Entities. Needed actions and the agencies and entities that will take the lead on pursuing them, and be accountable for results.

I. A Person-Centered Culture

Why is this important?

Person-centered thinking is a philosophy underlying service delivery that supports people in exerting positive control and self-direction in their own lives. Person-centered thinking is important for the promotion of health, wellness and safety, and for supporting people with disabilities to be valued and contributing members of the community.

While the use of person-centered thinking is important in all service contexts, its adoption by service providers working with people transitioning out of institutionalized settings is particularly crucial. It can increase the likelihood that service plans will be used and acted upon, that updating service plans will occur "naturally," needing less effort and time, and that the person's ability to lead a fulfilling, independent life will be maximized.

What is the Vision?

The vision is for a culture in our city that deeply respects each person's right to make independent decisions about all facets of his or her life. We envision an LTSS system that fully embraces person-centered thinking – in the kinds of services and supports that are provided, they ways in which they are provided and the central role of people with disabilities in all aspects of decision-making about the programs and services they wish to utilize.

What are Some of the Challenges the District Faces?

The road to culture change is long. While a few departments have had notable success in fully embedding person-centered thinking and practice into its culture and work, looking across the city government, awareness, capacity and competence in this area is uneven and can vary depending on agency or source of funding. There are no specified cross-system expectations or performance measures in this area for District agencies.

Action Steps, Lead Entities and Timeframes

The District's *No Wrong Door* initiative has articulated and is moving forward on a series of specific objectives for establishing a person-centered culture. These objectives center around improved accountability for the use of person-centered practice; widespread training in the methodology to increase capacity; and a reduction in duplicative intake and planning processes that tend to undermine person-centered approaches.

No Wrong Door's cross-agency Leadership Council and project team will lead the work to accomplish the following objectives during the first year of the city's implementation grant (fiscal year 2016):

1. Develop and implement clear expectations, competency criteria, standards, policies and protocols for all LTSS staff in the consistent use of person-centered approaches to service and planning, including using principles of supported decision-making (regardless of whether individuals have guardians or other substitute healthcare decision-makers).

2. Add person-centered practice standards to District personnel job descriptions for staff in key LTSS agencies.

3. Develop procedures and protocols for supporting family members and others in a person's support network to ensure that plans accurately and continuously reflect the individual's preferences and needs.

Measuring Progress Going Forward

Baseline data and planned metrics to evaluate improvements in the use of person-centered approaches are listed here without numerical values, as markers for the 2017 Olmstead Plan. During 2016, the Olmstead Working Group will develop specific strategies for gathering these data.

- #/% of core LTSS agencies that have implemented person-centered service protocols.
- #/% of performance measures (for agencies and providers) linked to person-centered practice and the use of supported decision-making.
- #/% of core LTSS agencies and staff that have completed training.
- #/% of HCBS provider staff who have completed training.

II. Community Engagement, Outreach and Training

Why is this important?

A robust, transparent system of Long Term Service and Supports requires the active participation of people with disabilities, family members and caretakers, advocates and local service providers. The active engagement of broad stakeholders also demonstrates the District's commitment to supporting people to make their own choices and lead their lives as they choose. Finally, ensuring people with disabilities are involved and engaged will keep agencies and providers focused on the right outcomes, and ensure they are addressing the barriers that people are facing every day -- many of which may not be obvious when the experience is not lived.

What is the Vision?

We envision a wide variety of high-impact community engagement, outreach and training strategies to ensure people with disabilities have ongoing, meaningful involvement in planning for, and executing, their own service and support plans. We envision an engagement, outreach and training infrastructure and support system that is efficient, effective, and person-centered; and that government commitments in these areas are not only transparent to the community, but are met in the defined timeframes.

What are Some of the Challenges the District Faces?

Limited community engagement opportunities. Much of the planning around community engagement work currently leaves key decision-makers (i.e. people with disabilities, service recipients, caregivers and families) out of the process altogether. In addition, participation in decision-making is often limited to formal work development and comment periods, which are not accessible to a broad range of stakeholders.

Current outreach misses key targets. Finding and engaging at-risk populations can be difficult, as is developing messages that resonate across all stakeholder groups. That said, current outreach and information dissemination across agencies and settings is not coordinated, resulting in duplication and confusion among recipients of the material. Further, there are few opportunities for in-person exposure to the Long Term Services and Supports that are available – outreach efforts are almost exclusively through printed materials as well as electronic, TV, radio, and social media communication. The District does not currently measure the effectiveness of its outreach efforts.

Planful training. Community trainings tend to be general or conducted *ad hoc*, rather than following a plan that is based on a needs analysis, goal setting, and attendee feedback. There are no District-wide training goals or basic training expectations for all agency staff. Trainings are often conducted in places that are not convenient for attendees and they are rarely evaluated in a meaningful way.

Action Steps, Lead Entities and Timeframes

Through the *No Wrong Door* initiative, DC has made strides in moving toward a unified approach to community engagement, outreach, and training. The NWD Stakeholder Engagement Workgroup developed a comprehensive contact list across all affected communities and convened the Outreach or Public Engagement staff at each NWD partner agency to brainstorm strategies for better work and inter-agency collaboration. The Workgroup also conducted several stakeholder engagement sessions and held preliminary focus groups with people with I/DD, physical disabilities, older adults, District-wide intake staff, and ADRC staff.

Building on this work:

1. Develop and promulgate policy and protocols to increase linguistically and culturally diverse stakeholder involvement in the development, implementation and ongoing evaluation of engagement and outreach activities (NWD/DDS by December, 2016).

2. Develop mandatory training for front line staff of District *No Wrong Door* partner agencies about the key plans and practice changes being developed through NWD. (NWD/DDS by December, 2016).

3. Develop a unified messaging and marketing "look" for outreach materials and replicate on all *No Wrong Door* partner agencies' websites (NWD/DDS by December, 2016).

4. Launch and publicize an "Olmstead-comments-and-questions" email address that is permanently live. ODR will collect comments and present them to the Olmstead Working Group's quarterly meetings for review (ODR by January 2016).

Measuring Progress Going Forward

Baseline data and planned metrics to evaluate improvements in community engagement, outreach and training are listed here without numerical values, as markers for the 2017 Olmstead Plan. During 2016, the Olmstead Working Group will develop specific strategies for gathering these data.

- % of customers and # of caregivers reached through outreach and training.
- #/% reached who are not currently connected to services but may be at-risk.
- % of outreach meetings conducted in languages other than English.
- % of sessions receiving positive participant rating.
- # of active website information links, total and per agency; # of hits/month.

III. Employment

Why is this important?

Competitive and integrated employment – and the access to stable housing that it can bring – is a key pathway to the middle class. For people with disabilities employment also increases connections to the community, builds self-confidence and can lower rates of isolation and depression. Our city gains much from the perspectives and talents people with disabilities bring to the workforce, in addition to their positive impact on the economy in wages earned, taxes paid, and the purchase of goods and services.

What is the Vision?

All working-age people have access to – and are prepared for -- competitive and integrated employment that meets their individual interests, preferences and informed choices. Pursuing these opportunities is the first option explored in publicly-funded services and people with disabilities have the support they need to do so. The District of Columbia strives to be a model employer of people with disabilities.

What are Some of the Challenges the District Faces?

Disproportionate unemployment for people with disabilities. There is a significant gap in employment rates between DC residents with and without disabilities. According to the Census Bureau, 31% of DC residents with disabilities are employed, compared with 72% of people without disabilities. For working age District residents with cognitive disabilities (defined as having serious difficulty concentrating, remembering, or making decisions because of a physical, mental, or emotional condition) only 27% are employed.[xxiv] Only 13% of people with intellectual and developmental disabilities supported by DDA were competitively employed, slightly below the national rate of about 15%.[xxv] Many young people with disabilities are not successfully transitioning from school to work.

Support structures need strengthening. Agencies and community providers working to support employment for people with disabilities need targeted support to build capacity, ensure efforts utilize best practices in the field and are coordinated and aligned. While long-term employment supports are available through the HCBS IDD waiver, the EPD waiver does not offer such supports. Transportation, a critical work support, is also a barrier for many.

Larger employment trends in the District.[xxvi] The District's economy is thriving in many respects, with an overall unemployment rate of only 6.8% and demand for middle and high-skilled jobs improving steadily. However, there are also significant disparities in our city on several key economic indicators. For example, nearly 30% of DC households earn only about half of the city's median household income. Similarly, while unemployment city-wide is low and declining, in Wards 7 & 8 it remains in the double digits at 11.8 and 14.7% respectively. Further, unemployment amongst certain populations, such as African Americans and youth is high and significantly exceeds the national average.

The skills gap is an important factor in unemployment. Approximately 10% of DC residents have a high school diploma or less and 50% of these individuals are unemployed or under-employed. In a labor market where the demand for low skilled jobs is declining, the competition for low skilled jobs can be substantial.

Action Steps, Lead Entities and Timeframes

As described in Section I, the District is an *Employment First* state with multiple initiatives and collaborations underway seeking to improve employment outcomes for youth and adults with disabilities. Building on this work:

1. Review and realign (if necessary) structures across the workforce development system to better support people with disabilities. (WIC by December 2016).

2. Increase the capacity of staff across the system, focusing on managers and supervisors in developmental disability and vocational rehabilitation programs through a train-the-trainer model and virtual community of practice to reinforce onsite training and provide virtual coaching to support best practices (DDS by December, 2016).

Measuring Progress Going Forward

Baseline data and planned metrics to evaluate improvements in employment for people with disabilities are listed here without numerical values, as markers for the 2017 Olmstead Plan. During 2016, the Olmstead Working Group will develop specific strategies for gathering these data.

- #/% of people referred from DDA to RSA who maintain employment and have their cases successfully closed.
- #/% of people referred from DBH to RSA who maintain employment and have their cases successfully closed.
- # of people jointly served by RSA, DDA, DBH, DOES, DCPS.

IV. Housing

Why is this important?

The need for accessible, affordable, and consistent housing is the very foundation for any individual to obtain a stable, secure quality of life. Without housing, life is always in flux and focusing on addressing other needs like employment, social activities, and self-care is made substantially more difficult.

What is the Vision?

Quality permanent housing will be accessible, affordable, and available to all people with disabilities.

What are Some of the Challenges the District Faces?

An increasingly constricted housing market. As a jurisdiction that is entirely urban, DC faces some unique challenges. Residential and retail development are booming, creating a highly competitive rental market not favorable for low-income people, especially for people who have been living in long term care facilities for years, have limited sources of income, and need to identify rental housing to return to the community.

Lack of a housing continuum. In the District, the most viable housing options for low-income people with long term care needs (especially those under age 55), hover at two ends of the spectrum: either in long term care facilities or in completely independent apartments or single family homes. There are currently only three Assisted Living Facilities operating under the District's EPD Waiver Program, with a total of 61 beds. "Affordable housing" may be targeted for people in the 50-80% Adjusted Median Income (AMI) level, meaning it is not affordable to people with incomes at or below 30% of the area AMI.

Limited subsidies. For many people with disabilities who need rental assistance, housing subsidies are not readily available. The DC Housing Authority stopped accepting new applications for housing assistance in 2013 because there was no meaningful movement on its waiting list.

Environmental accessibility. In cases where people with disabilities have identified housing, but there are accessibility issues, it is often difficult to access needed home modification funds. In fact, some residents are unable to leave institutions due to lack of modifications such as grab bars or ramps. While the District does have programs that provide funds for such modifications, they are for limited populations (e.g., only for people on the EPD or ID/DD Waivers) and/or funds may be difficult to access because of program design.

Homelessness. Ending homelessness is one of the District's priority focus areas. In the homeless services program, the Department of Human Services assessed 40% of singles and 16% of adult heads of families entering shelters to have a disability in at least one of eight categories.[xxvii] This Olmstead plan recognizes that people with disabilities living in long term care facilities who want to return to the community, and do not have a home, may be at risk of joining DC's homeless population.

Action Steps, Lead Entities and Timeframes

1. Evaluate and improve access to the Handicapped Accessibility Improvement Program (HAIP), which provides assistance for housing adaptations costing $10,000-$30,000 (DHCD by December 2016).

2. Implement environmental accessibility pilot program to fund expedited housing adaptations up to $10,000 per person (DCOA and DHCD, by January 2016).

3. Determine methodology to evaluate housing needs for individuals who have been referred to the ADRC because they want to live in the community (DCOA by December 2016).

Measuring Progress Going Forward

Baseline data and planned metrics to evaluate improvements in housing are listed here without numerical values, as markers for the 2017 Olmstead Plan. During 2016, the Olmstead Working Group will develop specific strategies for gathering these data.

- #/% of people with disabilities whose discharge from an institutional setting is pending only housing.
- #/% of people who, during discharge planning, are successfully helped to secure permanent, affordable, suitable housing they did not have prior to entry.
- % of existing affordable DC housing stock (units) that is fully ADA compliant and accessible to this population.
- % of planned housing stock (units) that will be fully ADA compliant and accessible to this population.

V. Intake, Enrollment and Discharge Processes

Why is this important?

Consistent, coordinated and person-centered intake, enrollment and discharge processes increase people's decision-making power and reduce potential barriers to community integration. Further, streamlined processes reduce duplication and save resources that can be redirected elsewhere.

What is the Vision?

The District seeks intake, enrollment and discharge processes that are easy to access, efficient, coordinated, transparent and reflect throughout a person-centered approach. The vision is that discharge planning begins on the day of a person's admission into a facility and that all needed

discharge services and support start on the day a person leaves institutional care. In addition, all people with disabilities and their family members and supporters who encounter the LTSS system understand these processes and can utilize them seamlessly.

What are Some of the Challenges the District Faces?

Limited Data and Information Sharing. One of the principal barriers to seamless intake, enrollment and discharge processing is the inability of multiple involved agencies and partners to easily share information and data. This delays processing and necessitates duplication of work. At best, this is frustrating for consumers, but it can also have a negative impact on their choices, well-being and successful integration into the community.

Staff capacity. Staff from multiple agencies involved in multiple processes often do not have the full-system knowledge they need to effectively help people navigate through to a successful outcome. In addition, although most DC human services agencies have trained staff on person-centered thinking and planning, the full culture shift needed to infuse all of these processes with this approach has not yet been achieved.

Public understanding and awareness. Given the complexity of these processes, and a lack of a unified communication effort, it is not surprising that much of the public that would be eligible for LTSS has a limited or inaccurate understanding of what is available and how to access it.

Action Steps, Lead Entities and Timeframes

One of the primary objectives of the *No Wrong Door* initiative is the development of agency process and work flows that improve coordination and integration of functions while reducing or eliminating duplication of efforts in intake, screening, eligibility determinations, application processes, case management and other areas. Building on this work, the District will:

1. Develop a "person-centered profile" for use in District LTSS agencies with common information that can be collected by referral sources or state systems and shared to avoid duplication of effort (NWD/DDS by December, 2016).

2. Develop guidance and training for case managers and service coordinators to ensure that the plans they create at intake and enrollment reflect a person's preferences and needs, and plans are adjusted as necessary (NWD/DDS by December, 2016).

3. Develop a discharge manual to be used by both institutional and community-based professionals in collaboration with the Interagency Council on Homelessness (ICH) and make recommendations to improve the process, if needed (DCOA, DHCF, DBH, DOH, DDS, ICH by December, 2016).

Measuring Progress Going Forward

Baseline data and planned metrics to evaluate improvements in intake, enrollment and discharge processes are listed here without numerical values, as markers for the 2017 Olmstead Plan. During 2016, the Olmstead Working Group will develop specific strategies for gathering these data.

- % of relevant DC agency staff receiving training on HCBS services and discharge procedures.
- Average EPD and IDD Waiver enrollment times.
- # of public events/participants on LTSS system access and Medicaid Waiver protocols and processes.

VI. Quality of Institutional and Community-Based Services, Providers and Workforce

Why is this important?

People with disabilities rely on critical services and supports, as well as on the people who are employed to help them carry out basic personal care needs and activities of daily living. From receiving health care treatments, to accomplishing everyday tasks at home, to obtaining and maintaining employment, people who are dependent on someone else for support in critical areas are especially vulnerable to the quality of those services.

Quality, consumer-directed care and supports will lead to greater health and well-being; poor quality service can lead to depression, lack of self-confidence and reduced functioning. Quality services help ensure that people with disabilities will have a higher likelihood of achieving their dreams and being integrated in the community.

What is the Vision?

The goal of the District's LTSS service delivery system is to provide high quality care and services that are consistent with people's needs and preferences and promote independence and quality of life in the most integrated settings. Quality means:

- *Reliability:* will the person arrive on time?
- *Competence:* Is the person properly trained in the specific support needs? Is the person properly supervised?
- *Safety:* has the agency complied with required background checks? Is equipment properly maintained?
- *Respect:* Does the agency embrace and ensure the dignity and rights of people are respected and protected?
- *Choice:* are there a sufficient number of provider agencies available to provide needed supports when they are needed?

These are just a few of the questions that must be answered in the affirmative for people who rely on a service system.

What are Some of the Challenges the District Faces?

Workforce turnover and availability. In both institutions and among HCBS providers, maintaining high quality, high performing staff is a challenge, as is filling vacancies. With five major hospitals located in DC, there is significant competition for qualified providers to deliver clinical services including nursing, physical, occupational and speech therapy and mental health services. Licensing and regulatory requirements, while intended to ensure quality, can sometimes slow the recruitment of new providers of these services.

Service Gaps, Duplication and Underutilization. The District's current system is not fully aligned. There are gaps in services for some populations, duplication of other services, or services that are underutilized, and varying performance standards depending on the source of funding. For example, Medicaid does not fund case management outside of the two Medicaid Waivers, leaving some individuals without this critical support. At the same time, some individuals may be receiving case management from two or more agencies as not all case management is funded through Medicaid.

Meeting Quality Standards. Virtually all LTSS providers must comply with a panoply of Federal and District regulations that set standards for provider qualifications and quality of care. However, a robust regulatory environment does not, by itself, guarantee that services are high quality, consumer-focused and designed around the needs of the individual. Disparate, complicated standards and certification and licensing requirements across District agencies contribute to the problem.

Services for Individuals with Limited English Proficiency. The District must increase its capacity to provide multi-lingual LTSS as increasing numbers of people with limited English proficiency age and require more services.

Action Steps, Lead Entities and Timeframes

1. Assess and reduce duplication of services offered by Medicaid and DCOA (DHCF and DCOA by September, 2016).

2. Review and strengthen regulatory options to more effectively deal with quality issues when they arise (DHCF, DDS, DBH, DOH by December, 2016).

3. Review all providers' Language Access plans to ensure residents with limited English proficiency have access to linguistically and culturally appropriate services (DHCF and DDS by December, 2016).

4. Create a customer satisfaction survey to cover the five components of quality described above (Olmstead Working Group by December, 2016).

Measuring Progress Going Forward

Baseline data and planned metrics to evaluate improvements in the quality of providers are listed here without numerical values, as markers for the 2017 Olmstead Plan. During 2016, the Olmstead Working Group will develop specific strategies for gathering these data.

- #/% of ICF/IDDs that pass certification and licensing reviews with only standard level deficiencies or better.

- #/% of adult day health recertifications completed within designated timeframes.

- % of people who receive the services for which they have been assessed/referred.

- % of mandatory, annual HBCS training requirements that providers meet.

- #/% of people receiving supports from DDA spending fewer days/week in facility-based day programs.

VII. Supporting Children and Youth

Why is this important?

Ensuring that children and youth with disabilities are fully and equally integrated into the life of our city sends the clear message that the District values them. Encouraging and challenging all children and youth with disabilities to succeed academically will position them for success in the workforce and in life. Individuals with high school diplomas are less likely to be institutionalized or dependent on public benefits down the road. Further, seamless coordination between secondary school systems and adult service delivery systems can ensure a smooth transition for students with disabilities from child to adult supports, thus lowering the risk of institutionalization and the need for emergency or crisis services.

What is the Vision?

Children and youth with disabilities, and their families, will be supported so they can achieve self-determination, interdependence, productivity, integration, and inclusion in all facets of community life, including competitive, integrated employment.

What are Some of the Challenges the District Faces?

Information-sharing. There is limited data and information sharing across agencies working with transitioning youth and there remains low public awareness of the need for students to be trained on workforce competencies, and have a paid work experience prior to exit from high school.

Service gaps. Employers have limited capacity to work with students with disabilities who have complex needs, and limited job coaching is available to support on the job training for most students. Further, the city does not offer comprehensive peer-to-peer support for families to help them identify and connect with needed formal and informal supports for their children and youth with disabilities. And, families have further identified a need for better coordinated services and supports across the lifespan, particularly during the transitions from infant and toddler services to school, from school to employment and, as needed, to adult services.

Limited end goals. Guardianship is often seen as the only option for parents of children with disabilities rather than self-determination and supported decision-making.

Action Steps, Lead Entities And Timeframes

1. Develop an inter-agency plan to ensure that students with disabilities who graduate with a certificate (rather than a diploma), have at least one community-based, integrated paid work experience prior to school exit (DDS/RSA, DC public and charter schools, and DOES by December, 2016).

2. Increase the timely submission and completion of applications for adult DDA services for children with IDD who are in out of state residential facilities (DDA, CFSA by December, 2016).

3. Develop NWD Person-Centered Practices curriculum and train 2 NWD staff to deliver the training to public LTSS agencies, community partners (NWD/DDS by December, 2016).

Measuring Progress Going Forward

Baseline data and planned metrics to evaluate improvements in supporting children and youth are listed here without numerical values, as markers for the 2017 Olmstead Plan. During 2016, the Olmstead Working Group will develop specific strategies for gathering these data.

- #/% of youth receiving employment services in an integrated environment.

- #/% of students with disabilities who graduate with a certificate (rather than a diploma), who have at least one community-based, integrated paid work experience prior to school exit.

- # and ages of children and youth with intellectual disabilities currently in nursing facilities.

- #/% of youth in out of state residential facilities for whom submission and completion of applications for adult DDA services is completed 2-3 years before they age out.

VIII. Medicaid Waiver Management and Systems issues

Why is this important?

Home and community-based services (HCBS) offered through Medicaid Waiver programs are the backbone of the support system that people with disabilities need to remain in the community. The development and implementation of these Medicaid Waiver services must be cost effective and sustainable, yet also sufficient to meet the needs of a wide range of people. The effective management of the Medicaid Waivers improves access to the programs and increases visibility, satisfaction and, for participating individuals, quality of life. Simpler applications and systems can ensure a person with a disability understands the system and can make decisions on his or her own behalf.

What is the Vision?

The District's Medicaid Waiver HCBS services meet people's varied needs so they can avoid institutional services altogether, or minimize a necessary stay and transition back into the community without delay and receiving services on the day of discharge. People with disabilities are fully integrated in the community and able to live as independently as they can.

What are Some of the Challenges the District Faces?

Needed service Improvements. Medicaid Waiver services would be significantly improved through the increased use of technology to supplant some paid supports and implementation of self-directed services to increase choice and control on the part of people receiving services. People with disabilities in the District also need a broader range of services and supports, with an emphasis on employment.

Process Consistency. Medicaid Waiver service enrollment processes can be inconsistently followed and not maximally aligned across agencies and providers. As a result, people may exit institutional care without services being fully in place. A lack of coordinated communication protocols for stakeholders and the public at large exacerbates process concerns.

Trained Workforce. Service providers must have full knowledge about community resources and services as well as discharge planning and service enrollment processes. They must understand and be able to apply the principles of person-centeredness.

Unserved Populations. In the District, people with developmental disabilities and brain injury are not eligible for services from either the DDA or EPD Waiver program, even though they may be at significant risk for institutionalization. People diagnosed with DD after the age of 18, or with brain trauma/injury resulting in significant cognitive impairments are not eligible for DDA services if the injury occurred after age 18. If they are not physically disabled, they are not eligible for services under the EPD program either.

Costs. Medicaid Waiver costs continue to grow approximately 5% per year.

Action Steps, Lead Entities and Timeframes

Both DHCF and DDS have identified a need to procure a new case management system that can also perform critical quality management functions, and interface with existing eligibility and payment systems for the Medicaid program. Such a system should improve the efficiency in the operations of the Medicaid Waiver programs, quality assurance and subsequent satisfaction with service delivery.

Under No Wrong Door, District agencies will be collaborating to improve stakeholder engagement, outreach, marketing and communication regarding all LTSS services.

Building on this work:

1. Research a new Medicaid Waiver program for people with IDD who live in family homes, including services targeted to help families continue their support (DDS, DHCF by December, 2016).

2. Research trach-dependent residential supports in the IDD Waiver and for DOH/HRLA regulations (DDS, DOH by December, 2016).

3. Develop training on how to access Medicaid Waiver services and troubleshooting for agency and provider staff involved in the EPD Waiver process (DHCF, ADRC, DOH).

4. Develop and implement a Participant Directed Program, allowing people receiving EPD Waiver services to have responsibility for managing and directing all aspects of service delivery, including who provides the services and how the services are provided (DHCF by December 2016).

Measuring Progress Going Forward

Baseline data and planned metrics to evaluate improvements to Medicaid Waiver management and systems are listed here without numerical values, as markers for the 2017 Olmstead Plan. During 2016, the Olmstead Working Group will develop specific strategies for gathering these data.

- % decrease in average length of IDD and EPD Waiver application processes.
- #/% of Medicaid Waiver case managers who are conflict free.
- % of cases for which intake processes are followed 100% of the time.

IX. Wellness and Quality of Life

Why is this important?

Full community integration for people with disabilities is inextricably linked to good health, wellness and a host of other "intangibles" that contribute to the feeling that one has a high quality of life. While it may be difficult to define "high quality of life" precisely – and certainly the definition varies by individual – there are some core pillars, including: accessible, effective health care; abundant opportunities for recreation (indoor and outdoor); healthy and nutritious meals; and convenient and easy transportation to work, play and personal appointments. These are among the staples of a high quality life that all residents of the District should equally enjoy.

What is the Vision?

People with disabilities will have opportunities to fully engage in their communities and connect with others in ways that are meaningful and aligned with their personal choices and desires. People with disabilities will have access to a wide range of integrated services to ensure their health, well-being and quality of life.

What are Some of the Challenges the District Faces?

Health and Wellness Disparities. Across the country, and no less true in the District, people with disabilities are more likely to experience difficulties or delays in getting the health care they need; to not have had recommended annual check-ups and tests; to be overweight or obese, have lower rates of participation in fitness activities, and to use tobacco. People with

disabilities are also more likely to have high blood pressure, experience psychological distress, and receive less social and emotional support.[xxviii]

Community Integration and Engagement. In the District, 34% of adults with ID who participated in the National Core Indicators survey reported that they had no friends other than family or paid staff; this is higher than the national the rate of 24%.[xxix]

Limits in Transportation. While the District offers a wide array of transportation options, the programs are not aligned with each other. For example, WMATA's MetroAccess program has specific requirements, which are also used by Transport DC, operated by the Taxi Commission, but DCOA's transportation program operated by its grantee Seabury, does not use the same guidelines. This is also true of the transportation services offered by Medicaid for medical appointments. Knowledge about the nuances of available programming is not consistent across agencies and as a result, some services are oversubscribed, while others are underutilized. In order to fully leverage the District's transportation services for people with disabilities, the District must align and focus each entity's transportation offerings.

Action Steps, Lead Entities and Timeframes

1. More broadly implement a medical home primary care model successfully piloted with adults with IDD in community based residential settings (DDS, DHCF by December, 2016).

2. Increase inclusive daytime programming offerings and provide technical assistance and training to improve staff capacity at Adult Day Health providers, Senior Wellness Centers, Senior Centers, public libraries and DPR recreation centers (DPR, DCPL, DCOA, DDS by December 2016).

3. Assess and align the capacity of transportation providers to support the transportation needs of people with disabilities (DDS with DDOT, DCOA, WMATA, MTM by December, 2016).

Measuring Progress Going Forward

Baseline data and planned metrics to evaluate improvements in the wellness and quality of life are listed here without numerical values, as markers for the 2017 Olmstead Plan. During 2016, the Olmstead Working Group will develop specific strategies for gathering these data.

- #/% of medical professionals using the medical home primary care model.
- #/% of inclusive daytime program offerings.
- % of residents with disabilities who have access to parks, open spaces, and recreation facilities within a half-mile of where they live.
- #/% of people with disabilities using various transportation mechanisms.

Glossary of Acronyms

ADA: Americans with Disabilities Act
AFCH: Adult Foster Care Home
ALFs: Assisted living Facilities
APS: Adult Protective Services in DHS
ARDC: Aging and Disability Resource Center in DCOA
CFSA: Child and Family Services Agency
CMS: Center on Medicaid Services (federal agency)
CRFs: Community Residential Facilities
CSAs: Core Services Agencies (DBH subcontract)
DBH: Department of Behavioral Health
DCSRC: DC State Rehabilitation Council
DCHA: DC Housing Authority
DCOA: D.C. Office on Aging
DCPL: DC Public Libraries
DCPS: District of Columbia Public Schools
DCRA: DC Regulatory Authority
DD: Developmental Disabilities
DDC: DC Developmental Disabilities Council
DDOT: DC Department of Transportation
DDS: Department on Disability Services in DDS
DHCD: Department of Housing and Community Development
DHCF: Department of Health Care Finance
DHS: Department of Human Services
DMHHS: Deputy Mayor for Health and Human Services
DOC: Department of Corrections
DOES: Department of Employment Services
DOH: Department of Health
DPR: Department of Parks and Recreation
DYRS: Department of Youth Rehabilitation Services
EPD: Elderly and Persons with Disabilities
HAIP: Handicapped Accessibility Improvement Program in DHCD
HCBS: Home and Community Based Services
HRLA: Health Regulation and Licensing Administration in DOH
ICF/IDDs: Intermediate Care Facilities for individuals with Intellectual Disabilities
ICFs: Intermediate Care Facilities
ID: Intellectual Disabilities

ID/DD: Individuals with Developmental and Intellectual Disabilities
ILOB: Independent Living Older Blind Program
ILS: Independent Living Services
LOC: Level of Care
LOS: Length of Stay
LTSS: Long Term Services and Supports
MFP: Money Follows the Person Rebalancing Demonstration Grant
MH/BH: Mental Health/Behavioral Health
MHCRFs: Mental Health Community Residence Facilities
MTM: DC Non-Emergency Transportation
NCI: National Core Indicators
NWD: No Wrong Door
ODR: Office on Disability Rights
OSSE: Office of the State Superintendent for Education
PCP: Person-Centered Practice
PRTFs: Psychiatric Residential Treatment Facilities
RSA: Rehabilitation Services Administration in DDS
SILC: DC Statewide Independent Living Council
SIM: State Innovation Model
SNAP: Supplemental Nutrition Assistance in DHS Program
TANF: Temporary Assistance for Needy Families in DHS
VR: Vocational Rehabilitation
WMATA: Washington Metropolitan Area Transit Authority

Appendix A: ID/DD Waiver Services

DAY SERVICES

Employment Readiness
Employment Readiness (also known as Prevocational supports) services are designed with the intent to assist persons to learn basic work-related skills necessary to acquire and retain competitive employment based on the person's vocational preferences and abilities. Services include teaching concepts such as following and interpreting instructions; interpersonal skills, including building and maintaining relationships; Communication skills for communicating with supervisors, co-workers, and customers; travel skills; respecting the rights of others and understanding personal rights and responsibilities; decision-making skills and strategies; support for self-determination and self-advocacy; and budgeting and money management. Developing work skills which include, at a minimum, teaching the person the appropriate workplace attire, attitude, and conduct; work ethics; attendance and punctuality; task completion; job safety; attending to personal needs, such as personal hygiene or medication management; and interviewing skills. Services are expected to specifically involve strategies that enhance a person's employability in integrated community settings. Competitive employment or supported employments are considered successful outcomes of Employment Readiness services.

Day Habilitation Services
Day habilitation services are aimed at developing activities and skills acquisition to support or further integrate community opportunities outside of a person's home and assist the person in developing a full life within the community. Day habilitation services are aimed at developing meaningful adult activities and skills acquisition to: support or further community integration, inclusion, and exploration, improve communication skills; improve or maintain physical, occupational and/or speech and language functional skills; foster independence, self-determination and self-advocacy and autonomy; support people to build and maintain relationships; facilitate the exploration of employment and/or integrated retirement opportunities; help a person achieve valued social roles; and to foster and encourage people on their pathway to community integration, employment and the development of a full life in the person's community. Day habilitation can be provided as a one-to-one service to persons with intense medical/ behavioral supports who require a behavioral support plan or require intensive staffing and supports. Day habilitation services may also be delivered in small group settings at a ratio of one-to-three for people with higher intensity support needs. Small group day habilitation settings must include integrated skills building in the community and support access to the greater community

Individualized Day Supports
Individualized day supports services provide crucial habilitation supports in the community to ensure that a person's community integration is increased and the particular skills necessary for independence and community involvement outside the home are developed and maintained in ways that enhance community integration outcomes. These services and activities operate totally in the community and are focused on opportunities to increase a person's abilities. All Individualized Day Supports activities must be structured learning based events. Individualized Day Supports can be provided to people who choose to participate in structured activities in community settings; are transitioning into retirement activities; are interested in volunteerism and community services; or for those who previously participated in a day habilitation service setting and now wish to participate in a smaller and more individualized setting.

Supported Employment Services
Supported employment facilitates competitive work in integrated work settings for individuals with the most severe disabilities for whom competitive employment has not traditionally occurred, and who, because of the nature and severity of their disability, need ongoing support services in order to perform their job. Supported employment provides assistance such as job coaching, travel training, and customized employment. Supported Employment services can be delivered individually, entrepreneurial or in a small group settings.

RESIDENTIAL SERVICES

Companion Services
Companion services provide non-medical assistance and supervision to support a person's goals, desires, and needs as identified in the person's Individual Support Plan (ISP), and reflected in his or her Person-Centered Thinking and Discovery tools. Goals may be related to the person's safety, promotion of independence, community integration, and/or retirement. Companion services may be provided in a person's home or in the community.

Host Home Services
Host Home providers enables people to live in the community in a family-type setting that will support them to achieve their goals, participate in community life and activities, maintain their health, and retain or improve skills that are important to them, which may include activities of daily living, money management, travel, recreation, cooking, shopping, use of community resources, community safety, and other adaptive skills they identify that are needed to live in the community.

In-Home Support Services
In-Home Support Service is provided to persons living in their own home or living in their family member's home. In-Home Support services are blended services that provide habilitation, personal care and other support services to the person in their home. These services assist the person to reside successfully in their home as their primary place of residence.

Personal Care Services
Personal Care services are the activities that assist the person with activities of daily living (ADL's) including bathing, transferring, dressing, grooming, and assistance during meals, and assistance with difficulties with incontinence. Personal Care Services through the Waiver is offered an extension through the DC State Medicaid Plan Personal Care services. DC State Medicaid Plan Personal Care services must be exhausted prior to Waiver Personal Care can be used. Personal Care services through the DC State Medicaid Plan and the wavier must be provided by a Home Health Agency.

Respite Care Services
Respite care services are the provision of short-term, temporary relief to those who are caring for family members enrolled in the Waiver. Respite care will ensure that persons will continue to receive services and have access to community activities as described in their ISP/Plan of Care including transportation to and from the activities.

Residential Habilitation Services
Residential Habilitation Service is provided by an agency in a licensed home serving four to six persons that is owned or leased and operated by the agency. Residential Habilitation is a blended service that provides habilitation, personal care, nursing, other residential supports, and transportation to the persons living in the home.

Supported Living Services
Supported Living Service is provided by an agency in a home serving one to three persons. Supported Living is a blended service that covers habilitation, personal care, nursing, and other residential supports. Supported Living services can be provided either with or without transportation. A provider choosing to provide Supported Living services with transportation, must ensure the provision of transportation services are used to gain access to Waiver and other community services and activities for all persons living in the home.

CLINICAL SUPPORTS

Creative Art Therapies
Creative Art Therapies are professional services which include Art Therapy, Music Therapy, Dance Therapy, or Drama Therapy and are provided by a licensed or certified professional in their respective field of expertise. Art Therapies are intended to help a person to express and understand emotions through artistic expression and the creative process. The service can be used for the treatment of a person's behavioral or physiological health needs, including but not limited to improving self-image; fine and gross motor skill development; increasing communication skill; reducing maladaptive behaviors; and enhancing emotional expression and/ or adjustment. This service can be delivered at the provider's place of business, in a day habilitation program, one's own or family home, or provider operated home. Creative Arts Therapies services are available both as a one-to-one service for a person, and in small-group settings, not to exceed 1:4.

Dental
Dental services under this Waiver are identical to Dental services offered under DC Medicaid State Plan. Dental services for persons enrolled in the Waiver or Intermediary Care Facilities (ICF's) are reimbursed at an enhanced rate if the person requires additional support to successfully complete dental treatment. The Dentist must bill for the enhanced rate when providing services to those enrolled in the Waiver or ICF's. For persons enrolled in the Waiver between the ages of eighteen (18) and twenty-one (21), the DDS Service Coordinator shall ensure that Early and Periodic Screening, Diagnostic and Treatment benefits (EPSDT) are fully utilized and the Waiver service is not replacing or duplicating the service.

Behavior Support Services
Behavioral Support services are preventive and consultative services that focus on long-term behavioral supports to improve and maintain a person's long-term health, attitude, and behavior rather than short-term responses to immediate crises. Behavioral Support services assist to improve the person's independence and inclusion in their community.

Family Training Services
Family Training services provides coaching, consultation and other professional supports services offered to families or unpaid primary caregivers of persons enrolled in the Wavier. The training focuses on how to improve the caregivers support the person or gain a better understanding of the services outlined in the person's ISP/Plan of Care.

Skilled Nursing
Skilled Nursing Services are medical and preventative care activities related to serious or persistent health issues that treat and manage a condition. These services include health assessments and treatment, health related trainings, and education for persons receiving Waiver services and their caregivers. Skilled Nursing Services through the Waiver is offered an extension through the DC State Medicaid Plan. DC State Medicaid Plan Skilled Nursing Services must be exhausted prior to Waiver Skilled Nursing Services can be used. Skilled Nursing Services through the DC State Medicaid Plan and the Wavier must be provided by a Home Health Agency

Speech, Hearing and Language Services
Speech, Hearing and Language services are designed to evaluate and treat people with communicative, hearing, cognitive or swallowing disorders and assist them in achieving the highest level of functioning possible. These services should be provided in accordance with the person's ISP/Plan of Care. All Speech, Hearing and Language Therapy services should be monitored to determine which services are most appropriate to enhance the person's well-being and to meet the therapeutic goals

Occupational Therapy Services
Occupational therapy services are designed for a person to gain independence and promote development of fine, gross, and sensory motor skills, that are needed to function and socialize in their home, work, and community. In the case of an injury or debilitating illness, services focus on rehabilitation, allowing people to return to their daily routines at their highest level of function. All Occupational Therapy services should be monitored to determine which services are most appropriate to enhance the person's well-being and to meet the therapeutic goals. This service is delivered by a licensed practitioner and is delivered in the person's home or day service setting. For persons enrolled in the Waiver between the ages of eighteen (18) and twenty-one (21), the DDS Service Coordinator shall ensure that Early and Periodic Screening, Diagnostic and Treatment benefits (EPSDT) are fully utilized and the Waiver service is not replacing or duplicating the service.

Physical Therapy Services
Physical therapy services are designed to remediate impairments and disabilities that limit a person's physical ability. The services promotes functional mobility and physical abilities, improves quality of life and movement through examination, evaluation, diagnosis and physical intervention to maximize independence, prevent further disability, and maintain health. These services should be provided in accordance with the person's ISP/Plan of Care. All Physical Therapy services should be monitored to determine which services are most appropriate to enhance the person's well-being and to meet the therapeutic goals. This service is delivered by a licensed practitioner and is delivered in the person's home or day service setting. For persons enrolled in the Waiver between the ages of eighteen (18) and twenty-one (21), the DDS Service Coordinator shall ensure that Early and Periodic

Screening, Diagnostic and Treatment benefits (EPSDT) are fully utilized and the Waiver service is not replacing or duplicating the service.

Wellness Services

Wellness services are professional services which include Bereavement Counseling, Nutritional Counseling, Fitness Training, Massage Therapy, and Sexuality Education and are provided by a licensed or certified professional in their respective field of expertise. Fitness services can be delivered in small group settings at a ratio of one-to-two for people who want to exercise with a partner. These services assist in increasing persons' independence, participation, emotional wellbeing, and productivity in their home, work, and community. This service can be delivered at the provider's place of business, in a day habilitation program, one's own or family home, or provider operated home.

ASSISTIVE SUPPORTS

Environmental Accessibility Adaptations (EAA)
Environmental accessibility adaptations are adaptations to a home which are necessary to ensure the health, welfare and safety of the person, or which enables the person to function with greater independence in the home, and without which, the person would require institutionalization. Adaptations may include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or installation of specialized electric and plumbing. **Environmental Accessibility Adaptations** cannot increase the square footage of the person's home.

One-Time Transitional Services
One-Time Transitional Services are non-recurring set-up expenses for people who are transitioning from an institutional or another provider-operated living arrangement to a living arrangement in a private residence where the person is directly responsible for their own living expenses. One-Time Transitional Services is limited up to $5,000 (One-Time). Allowable expenses are those necessary to enable a person to establish a basic household and may include: (a) security deposits; (b) essential household furnishings; (c) set-up fees or deposits for utility or service access; (d) services necessary for the participant's health and safety such as pest eradication and one-time cleaning prior to occupancy; (e) moving expenses; (f) necessary home accessibility adaptations; and, (g) activities to assess need, arrange for and procure need resources.

Personal and Emergency Response Services (PERS)
A Personal and Emergency Response service is an electronic device that provides access to emergency assistance through a two-way communication system. The system connects to a twenty-four (24) hour operated call center and the person's home. PERS services are available to those who live alone, or who are alone for significant part of the day and have no regular caregiver for extended periods of time, and who otherwise would require extensive routine supervision.

Vehicle Modification Services
Vehicle Modifications services are physical adaptations or modifications to a vehicle, including the installation of a lift or other adaptations. Vehicle modifications can be made to vehicles owned by the person or the person's family, guardian, or other primary care giver that is not compensated through other Waiver support services. Vehicle Modifications are designed to help the person function with greater independence through the use of the adaptation.

Appendix B: EPD Waiver Services

HCBS Waiver for the Elderly and Persons with Physical Disabilities (EPD)

- Adult Day Health
- Assisted Living
- Case Management
- Chore Aide
- Environmental Accessibilities Adaptations (EAA)
- Home maker
- Individual Directed Goods and Services
- Occupational Therapy
- Participant-directed Community Services (PDCS)
- Personal Care Aide (PCA)
- Personal Emergency Response System (PERS)
- Physical Therapy
- Respite

Appendix C:
ADRC Transition Planning Process

1. **Referral to Aging and Disability Resource Center (ADRC) for Community Transition Services**
   Nursing facility social worker makes a referral to ADRC's Community Transition Program at request of resident and/or legally authorized representative. Upon receipt of the referral, ADRC assigns Transition Coordinator to follow-up with referring social worker to confirm that resident is eligible for transition services. If so, Transition Coordinator schedules appointment to meet with resident at the nursing facility for assessment.

2. **Assessment/Preference Interview Tool**
   Within three business days of establishing contact with the referring social worker, an assessment process is initiated using the Preference Screening Tool (see attachment X), which solicits information about the individual's living preferences in the community, community resources and informal supports available to him/her, and general health needs. The Preference Screening Tool is administered on-site at the facility by the ADRC Transition Coordinator after he/she has reviewed the community transition process with the resident and/or legally authorized representative and a consent form authorizing transition services has been signed by the aforementioned parties.

2. Initial Transition Services Checklist & Identifying Transition Needs
The ADRC Transition Coordinator utilizes an "Initial Transition Services Checklist" to guide the process of gathering all documentation required to advance the community transition process. The Checklist includes items such as: personal identification documents, financial and medical documentation, and applications for transportation services or public housing (see attachment X).

3. Decision-Making
Decisions about the appropriateness of a less restrictive setting are ultimately made by the resident and his or her legally authorized representative. In lieu of a legally authorized representative, a resident may elicit the support and input of family, friends, and/or other chosen supporters who can assist them with making decisions based on recommendations provided by the facility's interdisciplinary treatment team, commonly referred to as the "IDT." The IDT typically consists of the facility's physician, social worker, nurse, dietitian, and physical or occupational therapist.

If a resident , and/or their legally authorized representative disagrees with the IDT's assessment that treatment in a less restrictive setting is inappropriate (given the home and community-based supports for which the individual is eligible), the District's Long-Term Care (LTC) Ombudsman is available to serve as an independent advocate for the resident's position.

4. Developing Discharge Plan/Putting Services and Supports in Place

If a less restrictive setting is determined to be appropriate by the resident and/or legally authorized representative; and housing and sufficient resources to support transition have been identified, the ADRC Transition Coordinator works collaboratively with facility's social worker, and other DC agency partners (DHCF, ESA, DBH, DDS), to secure those resources. These might include: durable medical equipment, behavioral health services, day treatment services, home health services including skilled nursing care and personal care aide services, occupational therapy and physical therapy, and support for seeking employment. The Transition Coordinator also coordinates with the resident's informal supports when applicable (i.e. faith-based groups, family members, social clubs, and neighbors, as identified by the resident as key supporters).

5. Discharge and Transition to the Community

When the resident and/or legally authorized representative and IDT have collectively determined that all necessary supports and services have been put in place, the nursing facility's social worker convenes discharge planning meetings to schedule the resident's date of discharge and to finalize plans to ensure treatment in a less restrictive setting is safe for the individual.

Once the resident has been successfully transitioned back to the community, there are a number of options for ongoing case management services though the District's EPD Waiver program, ADRC's Money Follows the Person Demonstration, and the DCOA's Senior Service Network.

Appendix D

DISTRICT OF COLUMBIA
NO WRONG DOOR SYSTEM

The District envisions a user-friendly No Wrong Door (NWD) system that is designed for all people with disabilities, older adults, and their families/caregivers to have easy access to a full range of integrated long-term services and supports (LTSS) that is culturally and linguistically appropriate and competent, and tailored and responsive to all cultures. The NWD system will assist all people with disabilities and older adults to live their lives in dignity, maintain their independence long as possible in their homes, and remain fully included members of their communities.

Mission Statement

The District will create a network comprised of government and non-profit organizations that will engage in person and family/caregiver-centered planning and provide responsive and comprehensive information about and referrals for LTSS. The information received will enable people with disabilities, older adults, and their families/caregivers to make informed choices regarding the LTSS they prefer and need in order to live with dignity in their homes and be fully included in their communities.

Outcomes

- Access to LTSS will be streamlined by developing and implementing a single application process that is easy to use, available in multiple languages, and linked to the full range of LTSS across agencies and programs available in the District.
- The application process will result in increased awareness about the LTSS options available in the District, and provide people with disabilities, older adults, and their families/caregivers with reliable information about LTSS from government agencies and/or non-profit organizations they trust.

- LTSS planning will be person and family/caregiver-centered, culturally and linguistically competent, and focused on identifying what is important to and for each person who needs LTSS and their families/caregivers. The goal of person and family-centered LTSS planning is to enable all people with disabilities and older adults to live in their homes with dignity and be fully included in their communities.
- All people with disabilities, older adults, and their families will have streamlined access to integrated LTSS that are a blend of family/informal supports, community, and paid services that support dignity, independence, and community inclusion.
- The District's No Wrong Door system will promote and embody the principles of person-centeredness, self-determination, cultural and linguistic competency, and accessibility.

Goals

To accomplish the vision and mission, the District of Columbia's No Wrong Door system will:

- Offer one-on-one person- and family/caregiver-centered counseling that provides all people with disabilities and older adults access to LTSS based upon what is important to and for them and their families/caregivers;
- Be responsive to the cultural preferences, needs, and the diverse languages spoken by people with disabilities, older adults, and their families/caregivers who reside in the District; and
- Offer excellent customer service.

Objectives

The District of Columbia's No Wrong Door system will:

- Be easy to access, use, and understand;
- Be responsive to all ages and disability groups;
- Connect people to desired services and supports regardless of where they start seeking services;
- Respond to a person's stated and assessed preferences and needs through either the provision of direct services or linkages to other appropriate community-based, private and/or public services and supports;

- Use uniform methods to collect and/or summarize intake, assessment, and planning information that provides for streamlined application and eligibility processes for all public LTSS;
- Use consistent person-centered approaches;
- Coordinate comprehensive information, referral, and assistance to support informed choice;
- Support knowledgeable, well-trained, respectful, and culturally and linguistically competent staff.
- Support people to live with dignity in their homes, with the services they prefer and need to live as independently as possible and be fully included in all aspects of their communities;
- Be fiscally responsible and efficient and ensure all sources of services and support are offered and accessed to their fullest capacity; and,
- Link people with community-based LTSS through a coordinated and comprehensive network of public and private supports.

Endnotes

[i] 28 C.F.R. § 35.130(d)
[ii] 527 U.S. 581
[iii] Organizations participating in the Olmstead Working Group: DC Center for Independent Living; DC Coalition on Long Term Care; DC Department of Behavioral Health; DC Department of Health; DC Department of Health Care Finance; DC Department of Transportation; DC Department on Disability Services; DC Developmental Disabilities Council; DC Housing Authority; DC Long Term Care Ombudsman Program; DC Office on Aging; DC Office on Disability Rights; DC Quality Trust; DC Supporting Families Community of Practice; DC University Center on Developmental Disabilities; Executive Office of the Mayor; Office of the Deputy Mayor for Health and Human Services; United Spinal Association; Washington Legal Clinic for the Homeless.
[iv] The number of unique individuals receiving any institutional or community-based care that is paid for by Medicaid.
[v] This does not include IDD HCBS Waiver providers.
[vi] Due to a claims lag, fiscal year 2015 Medicaid expenditures are not available at the time of publishing.
[vii] DHS assesses the following categories of disability: "Alcohol Abuse," "Drug Abuse," "Both Alcohol and Drug Abuse," "Chronic Health Condition," Developmental," "HIV/AIDS," "Mental Health Problem," and "Physical."
[viii] FY 2015
[ix] FY 2015
[x] FY 2015
[xi] All numbers are for fiscal year 2015, October 1, 2014-September 30, 2014, unless otherwise noted. Numbers for calendar year 2015, January 1, 2015-December 31, 2015, were not available at the time of publishing.
[xii] Out of 3,529 unique individuals who received nursing facility services in FY14, 2,996 received services at an in-state facility, and 575 received services at an out-of-state facility. Given the overlap, some individuals received services at both in-state and out-of-state facilities during the year.

[xiii] For 4 individuals, length of stay is unknown.
[xiv] Includes transitions for those assisted by NHT and MFP, as well as those identified in MMIS data.
[xv] A complete listing and brief description of services available through the Home and Community Based Services Waiver for People with Intellectual and Developmental Disabilities can be found at Appendix A
[xvi] As of October 21, 2016.
[xvii] A complete list of the EPD Waiver services can be found at Appendix B.

[xviii] The enrollment and cap numbers for the Medicaid Waivers are based on the 2015 calendar year.
[xix] As of October 2016.
[xx] This total does not include assisted living facilities that do not receive Medicaid reimbursement. There are several assisted living facilities in the District that only accept private-pay patients.
[xxi] For a full description of the transition planning process used by the ADRC, see Appendix C.
[xxii] A more detailed description of the NWD mission, outcomes, goals and objectives can be found at Appendix D.
[xxiii] Led by DHCF, the SIM work brings together DOH, DBH, DHS, the Office of the DMHHS, Councilmember Yvette Alexander's office; community-based health and social service providers; private health insurers and beneficiary advocates.
[xxiv] 2013 American Community Survey (ACS), U.S. Bureau of the Census.
[xxv] John Butterworth *et al.,* StateData: The National Report on Employment Services and Outcomes (Institute for Community Inclusion (UCEDD) University of Massachussetts Boston 2014).
[xxvi] Data provided by the DC Department on Employment Services
[xxvii] DHS assesses the following categories of disability: "Alcohol Abuse," "Drug Abuse," "Both Alcohol and Drug Abuse," "Chronic Health Condition," Developmental," "HIV/AIDS," "Mental Health Problem," and "Physical."
[xxviii] *Healthy People 2020*, *Disability and Health*, *available on-line at:* http://healthypeople.gov/2020/TopicsObjectives2020/overview.aspx?topicid=9
[xxix] http://www.nationalcoreindicators.org/states/DC/.